United States Department of Labor
Employees' Compensation Appeals Board

H.C., Appellant	)	
and	)	**Docket No. 16-0323**
	)	**Issued: April 10, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Pittsburgh, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On December 8, 2015 appellant, through counsel, filed a timely appeal from a June 23, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has established more than a 12 percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

On appeal counsel contends that the report of OWCP's medical adviser cannot represent the weight of the medical evidence and, at a minimum, the case should be referred for an impartial medical examination.

FACTUAL HISTORY

On May 5, 2005 appellant, then a 55-year-old clerk, filed a traumatic injury claim (Form CA-1) contending that on May 3, 2005, while attempting to stop mail from spilling onto the floor, he suffered a muscle strain of his upper left arm. OWCP accepted appellant's claim for sprain of the left shoulder, left bicipital tenosynovitis, primary osteoarthritis left shoulder, and other affection of the left shoulder region. On April 4, 2007 appellant underwent an authorized left shoulder arthroscopy, subacromial decompression, distal clavicle excision, minor anterior labral debridement, and biceps tenotomy. He received wage-loss compensation benefits on the supplemental roll from April 4 to June 29, 2007. Appellant returned to a light-duty position on June 25, 2007 and full duty on July 2, 2007.

On October 26, 2010 OWCP referred appellant to Dr. Steven Mandel, a Board-certified neurologist, for a second opinion to determine the status of appellant's accepted left upper extremity conditions. In a December 8, 2010 report, Dr. Mandel indicated that, based upon appellant's ongoing clinical symptomatology and supported by an electromyogram (EMG) study, his diagnoses were left branchial plexopathy, left cubital tunnel, and left median neuropathy attributable to his accepted injury dated May 3, 2005. He noted that appellant's clinical complaints and objective physical findings, including an EMG study supported these conditions. Dr. Mandel noted that appellant's condition was not expected to return to his preinjury level, from a neurological perspective.

On December 10, 2010 OWCP doubled this claim with appellant's claim in Master File No. xxxxxx920. In that case, on January 4, 2008 appellant filed a claim for an occupational disease (Form CA-2) alleging that he sustained bilateral brachial plexus and other shoulder conditions causally related to repetitive use of his arms during his employment. The Board reviewed that claim on prior appeal. By decision dated December 23, 2015, the Board found that the well-reasoned opinions of the impartial medical examiners, Dr. Richard Katz, a Board-certified neurologist, and Dr. Karl Rosenfeld, a Board-certified orthopedic surgeon, established that appellant did not sustain bilateral brachial plexopathy or any other bilateral upper extremity condition causally related to the accepted conditions of his federal employment, as alleged. The facts and circumstances of File No. xxxxxx920 as set forth in the Board's prior decision are incorporated herein by reference.[3]

In a January 6, 2015 medical evaluation, Dr. Nicholas P. Diamond, an osteopath, listed appellant's diagnoses as follows: (1) post-traumatic left shoulder sprain and strain and

[3] Docket No. 15-1078 (issued December 23, 2015). In a May 8, 2014 report, Dr. Katz determined that the absence of lumbar atrophy, normal limb strength, deep tendon reflexes, and normal sensation, indicated that appellant had no brachial plexopathy, radiculopathy, or neuropathy. Dr. Rosenfeld, in a June 4, 2014 report, opined that appellant did not suffer a nerve injury as a result of his employment to either his right or left upper extremities, noted that appellant's multiple complaints were probably arthritic in nature and unrelated to his job setting, and indicated that appellant's diabetes may likely play a part.

acromioclavicular (AC) joint degenerative joint disease; (2) post-traumatic left shoulder subacromial bursitis and biceps tenosynovitis anterior labral fraying; (3) status post left shoulder arthroscopy with arthroscopic subacromial decompression, distal clavicle resection, anterior labral debridement; and biceps tenotomy; (4) repetitive use right shoulder strain and sprain with impingement; (5) bilateral, right greater than the left, brachial plexopathy, EMG positive, November 1, 2007 and March 10, 2010; (6) left carpal tunnel syndrome, EMG positive July 9, 2007; (7) bilateral upper extremity diabetic neuropathies EMG positive; and (8) bilateral elbow lateral epicondylitis per clinical impression. He found that appellant's employment injury of May 3, 2005 was the competent producing factor for these conditions.

Utilizing the diagnosis-based impairment (DBI) methodology for rating permanent impairments, Dr. Diamond determined that, pursuant to Table 15-5 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[4] appellant had a class 1 left shoulder acromioclavicular joint arthropathy with distal clavicle excision for a Class of Diagnosis (CDX) of 1, which had a default 10 percent impairment. He found a grade modifier for Functional History (GMFH) of 4, a grade modifier for Physical Examination (GMPE) of 4, and a grade modifier for Clinical Studies (GMCS) of 2. Applying the formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX) Dr. Diamond found (4-1) + (4-1) + (2-1), yielded a net adjustment of 7, and determined that the permanent left upper extremity impairment after net adjustment was 12 percent. He then found a class 1 moderate sensory deficit left lower trunk (C8) which had a CDX of 9 percent pursuant to Table 15-20 of the A.M.A., *Guides*.[5] This was modified by grade modifiers of 2 for clinical studies which yielded a net adjustment of 1 (2-1), for a left upper extremity impairment after net adjustment of 10 percent. Dr. Diamond also determined that a class 1 IV/V mild motor strength deficit left biceps (upper trunk brachial plexus) equaled 9 percent under Table 15-20 of the A.M.A., *Guides*,[6] which was adjusted by a GMFH of 4, GMCS of 2, for a net adjustment of 1, and a left upper extremity impairment after net adjustment of 13 percent. For entrapment neuropathy left median nerve at wrist, applying Table 15-23,[7] he found test findings of one, history of three and physical examination (decreased pinch) yielded three, which totaled seven for an average of two or a five percent impairment. The functional history assessment was four so the combined, permanent left upper extremity impairment was increased to six percent. Dr. Diamond determined that this yielded a final combined permanent left upper extremity impairment of 35 percent. He also found a permanent right upper extremity impairment of 24 percent.

On April 14, 2015 appellant filed a claim for a schedule award (Form CA-7).

On April 16, 2015 OWCP referred the case to OWCP's medical adviser for an evaluation of permanent impairment. In a June 2, 2015 response, OWCP's medical adviser determined that appellant had 12 percent permanent impairment of the left upper extremity based on Dr. Diamond's examination, in combination with other medical evaluations. He mentioned

[4] A.M.A., *Guides* 403.

[5] *Id.* at 435.

[6] *Id.* at 434.

[7] *Id.* at 449.

numerous listed items of medical evidence, including magnetic resonance imaging (MRI) scans of the left shoulder conducted on March 3, 2008 and October 12, 2012 in addition to the December 7, 2010 second opinion evaluation by Dr. Mandel. The medical adviser also referenced the medical reports of Drs. Katz and Rosenfeld. He noted that he did not accept the opinion of Dr. Diamond. The medical adviser noted that Dr. Diamond included impairment ratings for both left and right shoulders and, as the only accepted conditions were of the left shoulder, this was not appropriate. He noted that Dr. Diamond made awards for neurologic deficit and motor strength/sensory deficits that were not verified by other examiners. The medical adviser also noted that left median nerve neuropathy and carpal tunnel syndrome were not accepted conditions. He found permanent impairment of the left upper extremity of 12 percent. The medical adviser referenced Table 15-5 of the A.M.A., *Guides, Shoulder Regional Grid, Upper Extremity Impairment,* acromioclavicular injury or disease, class 1, distal clavicle resection, and noted that the default rating under DBI methodology is 10 percent, with a range of 8 to 12 percent.[8] He then utilized the Adjustment Grid and Grade Modifiers and determined that appellant had a functional history adjustment grade modifier of 2 from pain with some normal activities, a GMPE of 1 for no significant decrease in the range of motion (ROM), and a GMCS of 2, as clinical studies confirmed lesions of rotator cuff/SLAP labral tear of biceps tendon. He then determined that utilizing the net adjustment formula, the net adjustment was +2, and when added to the default value of grade C, increased to grade E, for 12 percent permanent impairment.

By decision dated June 23, 2015, OWCP issued a schedule award for 12 percent permanent impairment of the left upper extremity.

LEGAL PRECEDENT

Section 8149 of FECA delegates to the Secretary of Labor the authority to prescribe rules and regulations for the administration and enforcement of FECA. The Secretary of Labor has vested the authority to implement the FECA program with the Director of OWCP.[9] Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.[10] FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. Through its implementing

[8] The medical adviser stated that appellant had a class 2 impairment and noted a default value of 10 percent with a range of 8 to 12 percent. However, a class 1 impairment has a default value of 8 to 12 percent, not a class 2. *See* A.M.A., *Guides*, 403, Table 15-5. When discussing grade modifiers, the medical adviser correctly noted that appellant was graded with a class 1 impairment. Therefore, it appears that his initial notation that appellant had a class 2 impairment was a typographical error.

[9] *See* 20 C.F.R. §§ 1.1-1.4.

[10] For a complete loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[11]

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within months of the initial printing, the A.M.A. issued a 52-page document entitled "Clarifications and Corrections, Sixth Edition, *Guides to the Evaluation of Permanent Impairment*." The document included various changes to the original text, intended to serve as an erratum/supplement to the first printing of the A.M.A., *Guides*. In April 2009, these changes were formally incorporated into the second printing of the sixth edition.

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[12] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[13]

ANALYSIS

The issue on appeal is whether appellant has established more than 12 percent permanent impairment of his left upper extremity for which he previously received a schedule award.

The Board finds that this case is not in posture for decision.

The Board has found that OWCP has inconsistently applied Chapter 15 of the sixth edition of the A.M.A., *Guides* when granting schedule awards for upper extremity claims. No consistent interpretation has been followed regarding the proper use of the DBI or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.[14] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[15] In *T.H.*, the Board concluded that OWCP physicians are at odds over the proper methodology for rating upper extremity impairment, having observed attending physicians, evaluating physicians, second opinion physicians, impartial medical examiners, and district medical advisers use both DBI and ROM methodologies interchangeably without any consistent basis. Furthermore, the Board has observed that physicians interchangeably cite to language in the first printing or the second printing when justifying use of either ROM or DBI methodology. Because OWCP's own physicians are inconsistent in the

[11] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[12] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

[13] *Isidoro Rivera*, 12 ECAB 348 (1961).

[14] *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

[15] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

application of the A.M.A., *Guides*, the Board finds that OWCP can no longer ensure consistent results and equal justice under the law for all claimants.[16]

In light of the conflicting interpretation by OWCP of the sixth edition with respect to upper extremity impairment ratings, it is incumbent upon OWCP, through its implementing regulations and/or internal procedures, to establish a consistent method for rating upper extremity impairment. In order to ensure consistent results and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the June 23, 2015 decision. Following OWCP's development of a consistent method for calculating permanent impairment for upper extremities to be applied uniformly, and such other development as may be deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for an upper extremity schedule award.

CONCLUSION

The Board finds this case not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the June 23, 2015 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: April 10, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board

[16] *Supra* note 14.